

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>003673</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>04/08/2015</b>
NAME OF PROVIDER OR SUPPLIER  <b>UNIVERSITY PLACE INC</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>1750 LINDBERG RD</b> <b>WEST LAFAYETTE, IN 47906</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	<p>INITIAL COMMENTS</p> <p>University Place Inc. was found to be in compliance with 410 IAC 16.2-5 in regard to the Investigation of Complaint #IN00168635.</p>	R 000			

Indiana State Department of Health

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE